METHODS AND STANDARDS OF REIMBURSEMENT
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E. Organ transplants

Subject to the availability of services, a reimbursement amount may be negotiated up to the fair compensation amount for such services. Payment will be made at the level of care reimbursement rate as described in Attachment 4.19 A, page 1. Payments to in-state hospitals may be negotiated up to 75% of billed charges, not to exceed $150,000. Payment to out-of –state hospitals may be negotiated up to 75% of billed charges.

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F. Indirect Medical Education (IME) Adjustment

Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increased operating, or patient care, costs that are associated with approved intern and resident programs.

1. In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital must:

   a) Belong to the Council on Teaching Hospitals or have a medical school affiliation; and

   b) Be licensed by the State of Oklahoma; and

   c) Have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs using the 1996 annual cost report.

2. Eligibility for an IME adjustment will be determined by the OHCA at the beginning of the state fiscal year, using the provider's 1996 completed annual cost report.

3. The annual payment amount for state fiscal year 1999 (base year) is $10,038,714, which will be paid out during the third quarter of the state fiscal year. For subsequent fiscal years, the payment will be made during the first quarter of the state fiscal year. The base year payment amount will be updated annually each July 1 using the first quarter publication of the DRI PPS-type Hospital market basket forecast for the midpoint of the upcoming fiscal year.

4. The annual payment will be distributed proportionately based on the number of interns and residents, to all providers who qualify according to the following formula: $10,038,714 x (total residents in the hospital's inpatient hospital program / total residents in all inpatient hospital programs. For hospitals that have public-private ownership, or have entered into a joint operating agreement, payment will be made to the public entity that is organizationally responsible for the public teaching mission.

5. If payment in paragraph F. (3) causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment in paragraph F. (3) will be reduced to not exceed the Medicare upper limit.

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G. Direct Medical Education Supplemental Incentive Payment Adjustment

Effective June 1, 1999, in-state qualified teaching hospitals will receive a supplemental payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of Managed Care capitated programs.

1. **Definitions**. For purposes of this amendment, the following definitions apply:
   Affiliation – means a written agreement to support the costs of medical residency education in an approved medical residency education program.
   Approved Medical Residency Program – a program approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. The Medical residency programs are those required for certification by the appropriate specialty board.
   FTE – stands for full-time equivalent. An FTE is defined as a resident assigned by the residency program to a rotation that is in a hospital or hospital-based facility for 173 hours or more for the month.
   Resident – defined as a Post-Graduate Year 1 (PGY1) and above resident who participates through hospital-based rotations in approved medical residency/internship programs in family medicine, internal medicine, pediatrics, surgery, ophthalmology, psychiatry, obstetrics/gynecology, anesthesiology, osteopathic medicine or other residency program, including specialties and sub-specialties. The medical residency programs are those required for certification by the appropriate specialty board.
   Resident month – defined as a resident/intern FTE for a given month.
   Major Teaching Hospital – defined as a teaching hospital with 150 or more FTE residents enrolled in teaching programs.
   Public/Private hospital – defined as a hospital owned by the State of Oklahoma that has entered into a joint operating agreement with a private hospital system.

2. **Eligibility.** In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

   a) licensed by the State of Oklahoma; and
   b) have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine and/or associated specialties and sub-specialties; and
   c) apply for certification to the OHCA prior to receiving payments for any quarter during a State Fiscal year. To qualify a hospital must have a contract with the Oklahoma Health Care Authority (OHCA) to provide Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program.

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Federal and State Hospitals, including Veteran's Administration Indian Health Service/Tribal Facilities and Oklahoma Department of Mental Healthy facilities are not eligible for supplemental DME payments under this section. Major teaching hospitals, as defined in 4.19-A, page17, Part F, are eligible.

3. **Determination of the Count of Eligible Resident FTE.** The resident must be assigned to a specific hospital for a supervised hospital-based experience. Required residency, clinical or educational experience will be allowed. Rotations that are primarily clinical, even though involving some hospital training are not counted as resident-months. Training outside the formal residency program (moonlighting and overtime) is not eligible for this payment.

4. **Reporting Requirements.** Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident-months of support provided by the hospital and be attested to by the hospital's administrator or designated personnel and by the residency program director. The hospitals, at a minimum, will report the residents' name Social Security #, hours worked, total assigned resident-months for the quarter and department of assignment. The reports will be subject to audit and payments will be recouped for inaccurate or false data. The reported resident-months will also be periodically compared to the annual budgets of thee schools, the annual HCFA form 2552 (Cost Report) and the monthly assignment schedules prepared by the schools.

5. **Allocation of Funds.** An annual fixed DME payment pool will be established based on the state matching contribution being made available for this purpose by other state agency sources and will not exceed $27,612,390. The payments will be distributed based on the number of resident-months at each participating hospital. For payment purposes, the number of resident-months will be weighted by factor of 2.0 towards Public/Private Major Teaching Hospitals. The pool of available funds will be paid out by quarter and will be Allocated to the hospitals based on the prior quarter's reported resident-months, weighted as described above. Formula: Total payment = [(Total Annual Pool/4) / weighted* resident-months] times,(X), resident-months for the quarter. * The resident-months for Public/Private Major Teaching facilities weighted at 2.0 and all others at 1.0.
6. **Upper Payment Limit.** If payment in G (5) causes total payments to exceed Medicare upper limits as required by CFR 447.272, the amount of payments over the limit will be recouped based on the total resident-months for that fiscal year. The upper payment limits will be determined in advance of the fiscal year from a compilation of the total allowable costs for all hospitals reported on the latest available HCFA 2552 cost reports compared to the reimbursement (including spend-down, TPL & co-payments) for the same periods as reported through the State MMIS.

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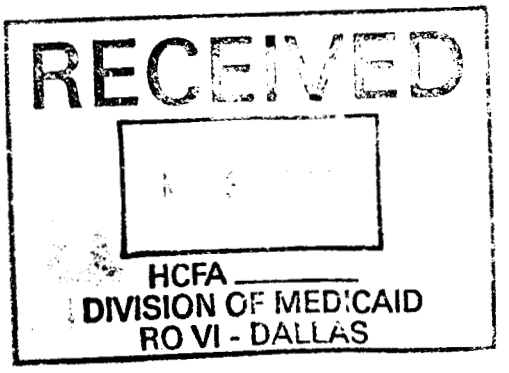
H.
8. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act..



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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

I.
H. Long Term Care Hospitals serving children. Effective for services provided on or after January 1, 1998 payment will be made to free -standing long term care hospitals serving children for subacute care level of services.

1. **Definitions:**

a. Long Tern Care Hospital Serving Children. A long term care hospital must have an average length of inpatient stay greater than 25 days.

b. Subacute Level of Care. Skilled care provided by a long term care hospital to patients with medically complex needs. Patients receiving treatment include: children with complex pulmonary problems; children requiring long-term care to improve or maintain their physical condition or prevent deterioration; children who are terminally ill; and children who are experiencing severe developmental disabilities and multi-handicaps.

c. Routine Services. Routine services should be patient specific and in accordance with standard medical care. Services include but are not limited to: regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care.

d. Children. For the purpose of this reimbursement rate children are defined as individuals under the age of 21.

2. **Eligible Providers**:

To be eligible for reimbursement hospitals must be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority. The facility must also be designated as a long term care facility by the Health Care Financing Administration and be licensed by the Oklahoma State Health Department as a Children's Specialty Hospital. Payment will be made to licensed Children's hospitals specializing in subacute nursing and rehabilitative services provided to children. The (*) facility must maintain an average daily census of 85% children to remain eligible for the reimbursement rate. The census must be based on the entire facility and not a distinct part.

(*) Pen and ink change authorized by phone 6/17/98

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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3. Reimbursement for Subacute Services

a. As of 5-01-00, the base rate for payments for subacute routine services is calculated as 85.7% of the existing statewide median total rehabilitation level of care per diem rate paid to non-teaching acute care hospitals without burn and NICU units. This base rate will be reviewed annually by use of cost reports, statistical patient data and other available information. Future changes to the rate, will be determined based on access and actual cost and when necessary, plan changes submitted to adjust the rate.

b. Subacute level of care hospitals will not be eligible for acute hospital leave or therapeutic leave.

4. Ancillary services

Refers to those services that are not considered inpatient routine services. Ancillary services may be billed separately to the Oklahoma Medicaid Program, unless reimbursement is available from Medicare or other insurance or benefits programs.

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